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Office of Administrative Law Judges
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Issue date: 24Jun2002

Case No: 1998-BTD-0002

In the Matter of

OLD BEN COAL COMPANY

Petitioner

v.

DIRECTOR, OFFICE OF WORKERS' COMPENSATION PROGRAMS

Respondent

and

HASKELL U. ABELL, Deceased Miner

Party-in-Interest

BEFORE: RUDOLF L. JANSEN
Administrative Law Judge

DECISION AND ORDER ON REMAND

This proceeding originally arose from a claim for benefits filed by Haskell U. Abell, a deceased miner, under Title IV of the Federal Coal Mine Health and Safety Act of 1969, as amended. 30 U.S.C. § 901 et seq. Black lung benefits were awarded to Mr. Abell, together with related medical benefit coverage. This case on remand involves the singular question of the extent of employer liability for the payment of Mr. Abell's medical expenses.

On June 8, 1999, I issued a Decision and Order denying any responsibility for reimbursement of the Black Lung Trust Fund by the Petitioner. In that decision, I found that the Director had not demonstrated by a preponderance of the evidence that the medical procedures at issue with respect to the reimbursement request were related to the miner's pneumoconiosis. On appeal by the Director, the decision was vacated and remanded to the Office of Administrative Law Judges by Decision and Order of the Benefits Review Board, BRB No. 99-1044 BLA, issued October 31, 2000.

The findings of fact and conclusions of law stated in the previous Decision and Order are adopted herein except to the extent that they were found to be erroneous by the Benefits Review Board, or to the extent that they are inconsistent with the findings and conclusions made in this Decision and Order on Remand.

Remand Order of the Benefits Review Board

The Benefits Review Board (Board), by Decision and Order dated October 31, 2000, remanded this case for reconsideration of all the evidence pertaining to the miner's medical expenses. The Board specifically requested consideration of three-hundred- thirty-four pages of medical bills, insurance claim forms, and progress and admission notes regarding hospitalizations of Mr. Abell between 1982 and 1988. The Board did not, at that time, discuss my findings with respect to the Director's failure to follow the regulations in this case.

FINDINGS OF FACT AND CONCLUSIONS OF LAW

Haskell U. Abell was awarded benefits under Part B of the Act pursuant to the June 24, 1974 decision of a Social Security Administration Administrative Law Judge. The miner filed an application for medical benefits on May 7, 1979 with the U.S. Department of Labor and was awarded medical benefits on October 15, 1979, but no responsible operator was identified and benefits were paid by the Black Lung Disability Trust Fund. Once a responsible operator was identified, an amended award of benefits was issued. The Employer submitted a controversion on June 11, 1984 and requested a formal hearing on May 8, 1985. Mr. Abell died on January 13, 1988. On January 17, 1989, a Department of Labor Administrative Law Judge issued a decision awarding medical benefits and attorney's fees. It was found that the miner had established forty years and nine months of coal mine employment. He ordered Old Ben Coal Company (hereinafter, "Employer") to pay all medical and hospital benefits to which Mr. Abell was entitled and previously incurred by him, and to reimburse the Trust Fund for any unreimbursed treatment costs incurred as a result of Mr. Abell's total disability due to pneumoconiosis. (DX 1). The decision was affirmed by the Benefits Review Board on April 21, 1992. (DX 2).

On February 8, 1993, the District Director requested reimbursement of medical bills from the Employer in the amount of $48,885.90. (DX 3). On January 31, 1996, this amount was revised to $45,398.64. (DX 6). On January 13, 1998, it was revised to $39,006.87. (DX 17). The parties finally agreed that the amount in dispute is $39,002.25.

The January 17, 1989 Decision Awarding Medical Benefits made extensive medical and other factual findings. (DX 1) All of those findings are incorporated herein.

Old Ben Coal Company did not contest that the miner suffered from pneumoconiosis in the medical benefits claim. The claim file contained numerous physical examination reports together with medical reviews by other physicians including treating physicians. The doctors expressed a variety of opinions including that the miner suffered a 100% disability due to pneumoconiosis and that he was a pulmonary cripple; that he was totally and permanently disabled because of his coal mining activity; that he was nearly house bound as early as October, 1984; that he suffered an impairment of emphysema with asthmatic component; that he suffered from severe obstructive pulmonary disease but no disability from that malady; that he suffered a very severe obstructive ventilatory defect sufficient to prevent him from performing his coal mine work; that he was totally disabled due to his airway obstructive disease; and his Death Certificate indicated that he died as a result of a sudden respiratory failure resulting from years of chronic obstructive pulmonary disease. On the Death Certificate, Claimant's long-time treating physician concluded that he was totally disabled from severe airway obstruction due to a combination of cigarette smoking and coal dust inhalation.

Summary of Medical Records (DX 03)

The record contains copies of "corrected" health insurance claims forms. (DX 03, pp. 2, 27-29, 47) These forms are not physician opinions, nor are they signed by a physician or other medical professional, but list medical procedures and their associated costs. These corrected forms have "COPD" and "Black Lung" handwritten as diagnoses, and attribute expenditures for oxygen to these diagnoses. The record does not contain the "uncorrected" or original versions of these forms. The record also contains insurance claim forms that are not corrected, which list COPD as a diagnosis, but not black lung or pneumoconiosis. (p. 30)

The record also contains bills and progress notes from the miner's hospitalization from December 26, 1987, to January 9, 1988. (pp.3-30) Mr. Abell was admitted to Gibson General Hospital for gastrointestinal bleeding, but was noted for known COPD, diabetes mellitus, and arteriosclerotic heart disease. (pp. 7, 20) The billing statements note "gastrointest hemorr," and expenses of $425.65 related to respiratory therapy, $245.00 for oxygen, $962.55 in non-itemized pharmacy expenses, $34.90 worth of theophylline, and a $12.55 oxygen gauge. (pp. 4, 10-12) These bills also contain various costs associated with intravenous administration of non-itemized pharmaceuticals. In his progress notes, William R. Wells, M.D., prescribes Erythromycin administered intravenously specifically for Mr. Abell's chronic obstructive pulmonary disease. (pp. 23-26) Dr. Wells also noted that Mr. Abell's COPD was being

treated with steroids, though he doesn't designate the specific drugs. (p. 7)

Mr. Abell was hospitalized from August 20, 1987, to August 26, 1987. (pp. 36-51) He again incurred expenses of $226.10 related to respiratory therapy, $112.00 for oxygen, $334.65 in non-itemized pharmacy expenses, a $12.55 oxygen gauge, and various other expenses related to the administration of oxygen. These bills also contain various costs associated with intravenous administration of non-itemized pharmaceuticals. Dr. Wells noted again that Mr. Abell was admitted with unstable angina pectoris, decompensated COPD, and diabetes mellitus. (p. 35) The only specified drug prescription was Vistaril for nervousness. (pp. 41-43)

The miner was hospitalized on April 23, 1987, admitted for decompensated COPD, chronic bronchitis, and acute bronchitis, receiving $308.60 in respiratory therapy services and $27.55 in non-itemized pharmaceuticals. (p. 53) A Health Insurance Claim Form demonstrates treatment with $21.75 of "Mucomyst $\pm$ Bronkosol," related to "diagnosis code" 492.8 and 428.0. (p. 57) A very faded hospital bill indicates an oxygen gauge and non-itemized pharmaceuticals were administered to the miner. (pp. 64-65)

Mr. Abell was hospitalized on April 11, 1987. (pp. 59-63) Krishma Murthy, M.D., provided a consultation, noting shortness of breath and a productive cough, diagnosing acute COPD, acute bronchitis, congestive heart failure and an irregular heart beat. (pp. 69-70) The Health Insurance Claims Forms indicate billing for the hospitalization and the consultation report, as well as an arterial blood gas, and EKG interpretation. (p. 67) The medical bill from Gibson General Hospital noted, among other things, $803.90 in non-itemized respiratory therapy services and $735.00 in non-itemized pharmaceuticals. (p. 71) The bill also contains expenses of $270.59 in oxygen and related tubes and gauges. (pp. 71-80)

The record contains a progress note from Dr. Wells regarding Mr. Abell's April 11, 1987 hospitalization. (pp. 81, 88-91) The miner was admitted with acute bronchitis and was noted to have markedly decompensated COPD. Following a course of treatment, his bronchitis had improved and his COPD was well compensated. He was also noted to have severe arteriosclerotic heart disease with unstable angina pectoris. During this hospitalization, Mr. Abell suffered a setback which was either severe angina or a new myocardial infarction. Dr. Well's treated this setback with oxygen and nitroglycerin spray. He also prescribed Zyloprim for treatment of gout.

Dr. Murthy also provided a consultation report during this hospitalization. (p. 85) He also noted that Mr. Abell was admitted for breathing difficulties, and acknowledged known diagnoses of COPD, CWP, and recurrent respiratory infections. He

noted bronchoscopy findings consistent with coal dust and bronchitis in the bronchial tree, and a fifty to sixty pack per year smoking history. He diagnosed acute exacerbation of COPD by acute bronchitis and thick secretions in the upper airways, congestive heart failure, and multifocal atrial rhythms with frequent premature atrial beats. He recommended treatment with Aminophylline, Prednisone, Bronkosol, Lasix, and antibiotics.

A health insurance claim form lists expenses for an ER visit, Bronkosol, a "hand neb setup," and a "RT Single Pro." (pp. 92, 94) The form lists the diagnosis code 786.09, but does not indicate what this code stands for. A hospital bill also lists non-itemized respiratory therapy and emergency room expense, without reference to a diagnosis associated with these costs. (pp. 93, 95, 96)

Mr. Abell was hospitalized on March 16, 1987. Dr. Wells noted that Mr. Abell was admitted to the hospital in respiratory distress due to severely decompensated COPD. He was given Aminophylline, and his condition improved. (p. 97) He was given nitroglycerin and Demerol for his angina, and Darvocet for his pain, along with other medications without designation of the condition they were being used to treat. In his progress notes, Dr. Wells describes the course of treatment for Mr. Abell's angina and COPD. (pp. 105-109) The bill for the March 16 - 26, 1987 hospitalization includes itemized oxygen related expenses, non-itemized pharmaceutical expenses, and respiratory therapy expenses, many of which are barely legible. (pp. 98 -104)

Mr. Abell was hospitalized on February 18 - 25, 1987, admitted in acute respiratory distress. (p. 111) He also had severe angina prior to his admission. He was given Aminophylline, Cefobid, and steroids on admission, but it is unclear whether these pharmaceuticals were intended to address the angina or the respiratory distress. The bill for the February 18 - 25, 1987 hospitalization includes itemized oxygen related expenses, non-itemized pharmaceutical expenses, and respiratory therapy expenses. (pp. 110-115) Dr. Wells prescribed Solu-Medrol to treat the miner's shortness of breath. (p. 116) He also prescribed Lasix, Cefobid, Slo-bid, Restoril, Prednisone, and steroids, but didn't specifically identify the diagnosis being addressed by these pharmaceuticals.

Mr. Abell was hospitalized from December 26, 1986 through January 1, 1987 for rapid pulse and difficulty breathing. (p. 127) While hospitalized, a diagnostic fiberoptic bronchoscopy was performed on December 29, 1986, related to Mr. Abell's chronic obstructive lung disease and chronic bronchitis. (p. 121) He was prescribed a series of pharmaceuticals to treat his final diagnoses of acute bronchitis, pulmonary emphysema, diabetes mellitus, and angina pectoris. Dr. Wells' progress notes chronicle swallowing difficulties, chest pains, and breathing problems.

Health insurance claim forms list $315.00 of expenses in "concentrator oxygen," to treat chronic obstructive lung disease and "Black Lung." (pp. 138-139)

Mr. Abell was hospitalized on October 27, 1986, until November 3, 1986. During this hospitalization, he incurred respiratory therapy and pharmaceutical expenses. (pp. 141-146) He was admitted with severe respiratory decompensation, complicating his chronic obstructive pulmonary disease. His respiratory distress was specifically treated with Cefobid, Aminophylline, steroids, and Solu-Medrol. He was also given Glucotrol, Prednisone, Keflex, and some vitamins. In his Admitting Note, Dr. Wells identified Aminophylline and Bronkosol specifically to treat Mr. Abell's breathing difficulties. (p. 153) Gibson General Hospital's bill includes charges for respiratory therapy services, oxygen, and pharmaceuticals related to Mr. Abell's treatment. (pp. 161-164)

Mr. Abell was hospitalized from October 20, 1986, until October 26, 1986. During this hospitalization, he incurred respiratory therapy and pharmaceutical expenses. (pp. 182-186) He was admitted with acute respiratory decompensation and treated in Dr. Wells' absence by Dr. Funke[1]. (p. 187) Dr. Funke placed Mr. Abell on Aminophylline, Kefzol, and Solu-Medrol, while continuing his Coumadin, Lasix, Lanoxin, and Triavil.

Mr. Abell was hospitalized from September 29, 1986, until October 4, 1986, for chest tightness, pain in both arms, shortness of breath, and nausea. The admission notes indicated a prior treatment of a throat infection with Nizoral. On admission, Dr. Murthy noted respiratory distress, wheezing, tachycardia, severe hypoxemia on arterial blood gas studies, and a chest x-ray showing hyperinflation but no lung infiltrates. (p. 211) The Gibson General Hospital bill indicated various respiratory therapy services, oxygen, and non-itemized pharmaceutical expenses. (pp. 213-217)

The miner was hospitalized from August 10, 1986, until August 15, 1986, with severe respiratory decompensation. (p. 224) He was treated with Aminophylline, Bronkosol, Venti-mask, Solu-cortef, Tobramycin, and Ampicillin, and was noted on discharge to be breathing better. The Gibson General Hospital bill indicated various respiratory therapy services, oxygen, oxygen related equipment, and non-itemized pharmaceutical expenses. (pp. 225-228) Dr. Wells' progress notes chronicle Mr. Abell's improvements, but note treatment of his respiratory distress with Lasix, and the use of antibiotics Tobramycin and Ampicillin.

Mr. Abell was hospitalized from July 18, 1986, until July 22, 1986, for acute respiratory distress and decompensated asthmatic

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[1] Dr. Funke's full name and credentials are not of record.

bronchitis. (p. 236) Dr. Wells noted the use of Aminophylline, Solu-Medrol, Lasix, and steroids to ease his breathing. He also identified Coumadin as an anticoagulant administered to Mr. Abell. The hospital bill indicated various respiratory therapy services, oxygen, oxygen related equipment, and non-itemized pharmaceutical expenses. (pp.237-240)

On July 9, 1986, the miner had a medical appointment, which included some laboratory testing. (pp.247-249)

Mr. Abell was hospitalized from May 19, 1985, until May 29, 1985, for severe chronic obstructive pulmonary disease, acutely decompensated. (pp. 251, 254) He was given Aminophylline and was noted to have angina, pedal edema, and hemoptysis. Dr. Wells initially treated him with Mandol and Solu-Medrol, adding oral Prednisone for a time. He was removed from the steroid Prednisone, in order to regulate his blood sugar. He was then given Amikacin, and on release from the hospital, given oxygen, Bronkosol, and Proventil. Dr. Murthy attributed Mr. Abell's breathing difficulties to his smoking history and his exposure to coal dust. (p. 255)

Mr. Abell was hospitalized from May 6, 1985, until May 12, 1985. (p. 263) He was admitted in acute pulmonary decompensation, with possible pneumonia. He was treated with Aminophylline and the antibiotic, Ancef. (p. 274) He was billed for various respiratory therapy, radiological, and laboratory services, oxygen, oxygen related equipment, and non-itemized pharmaceutical expenses. (pp. 265-269)

The miner was hospitalized from March 11, 1985, until March 19, 1985, for acute respiratory decompensation. (p. 278) He was placed on Aminophylline and Bronksol, and treated for heart arrhythmia and diabetes mellitus. (p. 280) It was recommended that he try to refrain from smoking cigarettes. He was billed for various respiratory therapy, radiological, and laboratory services, oxygen, oxygen related equipment, and non-itemized pharmaceutical expenses. (pp. 281-288)

Mr. Abell was hospitalized from February 22, 1985, until February 28, 1985, in acute respiratory distress and experiencing heart problems. (pp. 296-310) He was placed on oxygen, Aminophylline and Mandol. An arterial blood gas study was also performed. He was billed for various respiratory therapy, radiological, and laboratory services, oxygen, oxygen related equipment, and non-itemized pharmaceutical expenses. On February 26, 1985, Dr. Wells continued treatment of Mr. Abell's blood pressure with Lasix. (p. 310)

Mr. Abell was hospitalized on January 2, 1985, until January 8, 1985, with severe respiratory decompensation with some tachycardia and chest pain. (pp. 313-319) He was also

hospitalized on June 21, 1984, until July 1, 1984, for bronchopneumonia and decompensated chronic obstructive pulmonary disease. (pp. 321-322) His bronchopneumonia was shown to be Enterobacter aerogenes, which was treated with Cefobid, Gentimycin, and another illegible pharmaceutical. He was also given Micostatin for some oral stomatitis, Aminophylline, Lanoxin, and Ceclor.

The record contains a note regarding a hospitalization in April, 1984. (p. 326) The miner was admitted for acutely decompensated chronic obstructive pulmonary disease and a cardiac arrhythmia. He was treated with Aminophylline, Breathine, and Bronkosol. There is also an insurance claim form indicating emergency room treatment for chronic obstructive pulmonary disease and coughing up blood on March 23, 1983. (pp. 327-328)

He was hospitalized on January 1, 1984, until January 6, 1984, for chest pain and respiratory distress. (p. 324) He was placed on Aminophylline and Lanoxin, and on discharge was prescribed Monocycline, Lufyllin, Triavil, Coumadin, Sorbitrate, and Diabonese.

Mr. Abell was hospitalized on September 1, 1982, through, September 7, 1982, for "out of control" chronic obstructive pulmonary disease and a secondary infection. (p. 330) He was placed on Mandol and Coumadin, as well as Aminophylline and Keflex. He was also hospitalized July 2, 1982, until July 7, 1982, with bronchopneumonia, arteriosclerotic heart disease, and chronic obstructive pulmonary disease. (pp. 331-332)

Evidentiary Burdens

In my June 8, 1999 Decision and Order, I noted that the Fourth and Sixth Circuit Courts of Appeal had each addressed the issue of medical reimbursement differently, but that the Seventh Circuit had not yet addressed the issue. I followed the Sixth Circuit approach as explained in Glen Coal Co. v. Seals and Director, OWCP, 147 F.3d 502 (6th Cir. 1998), and declined to presume that the submitted expenses were related to pneumoconiosis. Since my initial Decision and Order was issued, the regulations have been amended, and the presumption created by Doris Coal v. Director, OWCP, 938 F.2d 492 (4th Cir. 1991) has been adopted by the Secretary. Twenty C.F.R. § 725.701(e) now provides:

> If a miner receives a medical service or supply, as described in this section, for any pulmonary disorder, there shall be a rebuttable presumption that the disorder is caused or aggravated by the miner's pneumoconiosis. The party liable for the payment of benefits may rebut the presumption by producing credible evidence that the medical service or supply provided was for a pulmonary disorder apart from those previously associated with the miner's disability, or was beyond that necessary to

> effectively treat a covered disorder, or was not for a pulmonary disorder at all.

Pursuant to 20 C.F.R. §725.2, this rebuttable presumption applies to all pending claims, including this one. Pursuant to National Mining Ass'n., et al. v. Dep't. of Labor, ___ F.3d ___, Case No. 01-5278 (D.C. Cir. June 14, 2002), § 725.701 is impermissibly retroactive as applied to circuits specifically rejecting the Doris Coal presumption, and the Secretary is prevented from imposing the presumption on circuits for cases filed before the promulgation of the amended regulations. Since the Seventh Circuit has neither adopted nor rejected the presumption, I will defer to the Secretary's preference in this case and apply the Doris Coal presumption in deciding this case.

In applying the amended regulations and the Doris Coal presumption, a burden of production is now placed upon the Employer. In my June 15, 2001 Order Denying Stay, I found that the evidence previously submitted by the Employer was sufficient to show that the miner's treatment was for a particular pulmonary disorder apart from the pneumoconiosis previously associated with the miner's disability. I found the opinions of Drs. Fino and Branscomb sufficient to rebut the regulatory presumption provided by section 725.701(e). I further found that, as the Employer's burden of production had been satisfied, the burdens of production and persuasion once again rested with the Director to demonstrate by a preponderance of the evidence that the medical bills represented in this case were necessary or related to treatment of disorders related to pneumoconiosis. I renew those findings here, making the application of the Doris Coal presumption inconsequential to the outcome of this case.

Discussion

The District Director asserts that Mr. Abell's chronic obstructive pulmonary disease, for which he received some of the medical treatments at issue here, is a covered pulmonary condition under the Act. The Director also contends that the amended regulations definition of legal pneumoconiosis includes chronic obstructive pulmonary disease. The Employer agrees that chronic obstructive pulmonary disease is a covered condition under the Act, if it is caused by exposure to coal dust. As discussed above, the burden is now on the Director to demonstrate the connection between Mr. Abell's coal dust exposure and his chronic obstructive pulmonary disease.

Twenty C.F.R. § 725.701(a) provides in pertinent part:

> (a) A miner who is determined to be eligible for benefits under this part or part 727 of this subchapter (see Sec. 725.4(d)) is entitled to medical benefits as set forth in this subpart as of the date of his or her claim...

As discussed above, and in my June 15, 2001 Order Denying Stay, the burden of production and persuasion rests with the Director, who must now demonstrate by a preponderance of the evidence that the claimed medical expenses are necessary or related to treatment of disorders related to pneumoconiosis. 20 C.F.R. §725.701(e).

According to the medical records, Mr. Abell was hospitalized approximately twenty-two times and had several doctor visits and laboratory tests performed in a period of less that seven years. (DX 03) During these periods he was prescribed various pharmaceuticals, therapy services, and oxygen, with all the related equipment. This case is not about whether coal dust can generally cause an obstructive defect, but, as I noted in my previous decision, this case boils down to whether Mr. Abell's exposure to coal dust was a cause or contributing factor to his chronic obstructive pulmonary disease.

The Decision and Order Awarding Medical Benefits together with the medical records included in the file show that Drs. Marion L. Connerley, James F. Peck, William R. Wells, and Krishma Murthy performed the basic medical treatment of this miner. Unfortunately, neither party offered the original medical opinions from these physicians as evidence in this case, and Judge Robert E. Kendrick noted documentary deficiencies in some of the opinions in that record. Statements by Dr. Wells, as summarized in the Decision and Order Awarding Medical Benefits, do not say that all hospitalizations and medical costs incurred were as a result of the miner′s coal workers′ pneumoconiosis or for palliative measures. As I noted previously, references to Dr. Wells′ medical records in the Decision Awarding Medical Benefits show more of the usage of chronic obstructive pulmonary disease rather than coal workers′ pneumoconiosis and it does not appear that he uses those terms synonymously. Dr. Wells did, apparently, conclude that the miner suffered from an airways obstruction due to exposure to both tobacco smoke and coal dust. (DX 01, p. 13) Dr. Murthy also, apparently, attributed Mr. Abell's obstructive defect to tobacco smoke and coal dust exposure. Since the original medical reports of these physicians were not made part of this record, I am limited in my ability to sufficiently weigh them against the newly submitted reports of record. I am also not afforded the benefit of a determination by Judge Kendrick from the Decision and Order Awarding Benefits regarding any possible causative effect from Mr. Abell's pneumoconiosis on his chronic obstructive pulmonary disease because pneumoconiosis was conceded at that stage, and, therefore, not discussed.

The newly submitted medical reports in this case are all from highly qualified physicians who come to opposite conclusions regarding the causative effects of Mr. Abell's pneumoconiosis on his chronic obstructive pulmonary disease. Ben V. Branscomb, M.D., concludes that, although studies may exist to the contrary, coal dust inhalation does not cause COPD. In Blakley v. Amax Coal Co.,

54 F.3d 1313 (7th Cir. 1995), the Seventh Circuit held that the "hostile-to-the-Act" rule allows a judge to "disregard medical testimony when a physician's testimony is affected by his subjective personal opinions about pneumoconiosis which are contrary to the congressional determinations implicit in the Act's provisions." The amended regulations demonstrate a specific determination that coal dust exposure can cause pulmonary obstruction. Dr. Branscomb's opinion is not limited to the "facts and medical opinions of [this] specific case," but shed light on the assumptions underlying his opinion. Id. His opinion does, however, have some probative value with respect to Mr. Abell's medical condition as he discusses Claimant's physical condition. While I accord his opinion less weight, I do not disregard it altogether.

Contained in the almost four-hundred pages of medical records in this case, Dr. Murthy attributes Mr. Abell's "chronic airflow limitation" to his exposure to coal dust and cigarette smoke, but doesn't specify whether this "limitation" is obstructive or restrictive in nature. (DX 03, p. 255) As this opinion is vague with respect to the specific breathing difficulty, it is entitled to less weight. Island Creek Coal Co. v. Holdman, 202 F.3d 873 (6th Cir. 2000).

Gregory J. Fino, M.D., and Michael Sherman, M.D., offer well reasoned opinions based upon conflicting medical studies. Dr. Sherman's opinion is bolstered by the less probative summaries of the opinions of Drs. Connerley, Peck, Wells and Murthy, while Dr. Fino's opinion is supported by the less probative opinion of Dr. Branscomb. I find that these opinions weighed together are equally probative on the issue of whether Mr. Abell's COPD was caused or contributed to by his coal mine employment. It is the Director's burden to demonstrate by a preponderance of the evidence that Mr. Abell's medical treatment relates to his pneumoconiosis. Where the evidence is equally probative, the Director has necessarily failed to carry his burden. Director, OWCP v. Greenwich Collieries, et al., 114 S. Ct. 2251 (1994). The evidence of record does not demonstrate by a preponderance that the miner's COPD was caused by his exposure to coal dust.

In this case, nearly all of Mr. Abell's hospitalizations were for diagnoses which included decompensation of his COPD, some form of pneumonia, or acute respiratory distress. There is no evidence in this record as to what caused Mr. Abell's COPD to become decompensated or result in acute respiratory distress. During the May 19, 1985 hospitalization, Dr. Murthy's progress notes attribute Mr. Abell's "breathing difficulties" to his smoking history and coal dust exposure. (DX 03, p. 255) This single line in his note does not define the "difficulties" to include his then current distress or his general breathing obstruction. Taking this note in conjunction with his previous medical opinions, as summarized in

the Decision and Order Awarding Benefits, it is reasonable to conclude that Dr. Murthy attributed the miner's COPD, in part, to his coal dust exposure. As discussed above, however, this reasonable conclusion neither demonstrates by a preponderance of the evidence that Mr. Abell's COPD was due to his coal dust exposure, nor that the treatments provided were related to his pneumoconiosis.

In her brief, the Director lists pharmaceuticals and therapies prescribed to Mr. Abell by Drs. Wells and Murthy. The Director offers definitions from medical manuals demonstrating that these drugs and therapies were pulmonary in nature. While some of these drugs and therapies may have been useful for treatment of Mr. Abell's COPD, there is no evidence that Dr. Wells was using these therapies for treatment of pneumoconiosis. For instance, during his April 11, 1987 hospitalization, Mr. Abell suffered a setback of angina or myocardial infarction. The Director asserts that the only treatment related to his cardiac condition at that time was serum digoxin and Prothrombin Time. In Dr. Wells' notes however, he specifically used oxygen as part of his cardiac therapy. The Director cannot demonstrate that a specific treatment was used for pneumoconiosis by simply looking up the treatment in a handbook, but not offering medical opinions sufficient to demonstrate by a preponderance of the evidence that the treatment was, in fact, used for the treatment of pneumoconiosis.

Out of all the medical records in Director's Exhibit 03, the only items purportedly relating to pneumoconiosis are Health Insurance Claim Forms. Even after reviewing this case on appeal, the Board noted only that the record contained "numerous health insurance claim forms where black lung (sometimes very faintly) is listed under 'diagnosis.'" These forms are not signed by a physician for the purposes of diagnosis, but are generated for reimbursement for medical services provided. The forms referencing "Black Lung" are all "corrected" forms, for which the original is not in this record. These forms, which are mostly typewritten, have the diagnosis of Black Lung and COPD handwritten in the "diagnosis" section. The handwriting is not signed, nor is it attributed to a physician. The record offers no suggestion as to who may have referenced "black lung" on these forms.

Previous insurance claims forms have not been consistent with the diagnoses made in the progress notes. During his April 1984 hospitalization, Mr. Abell was diagnosed by Dr. Wells with COPD and cardiac arrhythmia, but the insurance claim form cites expenses related to diagnoses, including ones not discussed or described differently by Dr. Wells, of COPD, acute respiratory decompensation, acute tachycardia, PAC secondary, and diabetes mellitus.

Further, these "corrected" forms citing black lung pertain to hospitalizations for which pneumoconiosis is neither diagnosed nor discussed in the doctor's notes. Health insurance claim forms that have not been "corrected" list COPD as a diagnosis, but not pneumoconiosis. There is no evidence as to why and how these bills were corrected, causing concern over the trustworthiness of the documents. Accordingly, I accord these insurance forms little probative value for demonstrating a connection between treatments provided and the miner's pneumoconiosis.

In my original Decision and Order, I outlined the regulatory scheme to be followed in this type of matter. That discussion is incorporated herein by reference. I continue to find that this record shows that the Respondent has failed to comply with its own regulations, and has introduced no statements from the physicians who directed the hospitalizations or who treated the miner in support of its contention that reimbursement is warranted. I am still hard pressed to conclude that the Respondent has carried either its burden of proof or its burden of production with respect to the question of relatedness. There remains no question in my mind but that a good part of these expenses are related to the miner′s totally disabling pneumoconiosis and ought to have been paid by the Responsible Operator. Even after a painstaking review of the medical bills and records in this case, I continue to find that the Respondent has wholly failed to carry its burden of proof.

ORDER

For the foregoing reasons, IT IS ORDERED that Old Ben Coal Company is not responsible for the reimbursement of any of the medical expenses and related items paid by the Black Lung Disability Trust Fund for the medical treatment of Haskell U. Abell.

A

Rudolf L. Jansen
Administrative Law Judge

NOTICE OF APPEAL RIGHTS: Pursuant to 20 C.F.R. §725.481, any party dissatisfied with this Decision and Order may appeal it to the Benefits Review Board within thirty (30) days from the date of this Decision by filing a Notice of Appeal with the Benefits Review Board at P.O. Box 37601, Washington D.C. 20013—7601. A copy of this

Notice of Appeal also must be served on Donald S. Shire, Associate Solicitor for Black Lung Benefits, 200 Constitution Avenue. N.W., Room N-2605, Washington, D.C. 20210.